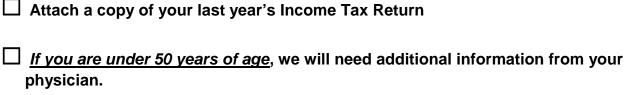
Enrollment Application Checklist

Please use the following checklist to ensure submission of all required information and timely determination of eligibility to the program.



- WCCSP Enrollment Application
 - Answer all questions on both sides of the form
 - Please print clearly in blue or black ink
- Informed Consent and Release of Medical Information
- o Affidavit of Wyoming Residency



 Please include the name and phone number of your physician on the second page of the application.

☐ Please submit the above information to the WCCSP by mail or fax:

Mailing Address: Wyoming Colorectal Cancer Screening Program

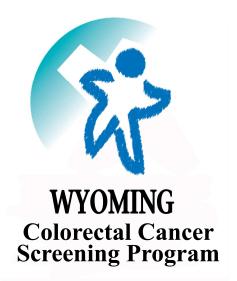
6101 Yellowstone Road, Suite 510

Cheyenne, WY 82002

Fax: (307) 777-1950

Please direct questions to Wanda Webb at (307) 587-4164 or 1-866-205-5292 or wanda.webb@wyo.gov

Document revised 01/27/2012



Colon Cancer Terms and Definitions

Colonoscopy - This is a test that looks for polyps in the entire colon. A doctor puts a long, flexible tube inside the anus and in the entire colon to allow him or her to see any polyps inside. Most polyps can be removed during the test. This test is usually done every 10 years or as recommended by your doctor.

Crohn's Disease - Crohn's disease is an ongoing disorder that causes inflammation of the digestive tract, also referred to as the gastrointestinal (GI) tract.

Double-Contrast Barium Enema- This test is conducted in a radiology center or hospital. This procedure involves taking x-rays of the rectum and colon after you are given an enema with a barium solution, followed by an injection of air.

Familial Adenomatous Polyposis (FAP) - **Familial** means that it runs in families. Each child of an affected parent has a 50% risk of inheriting the disease gene. **Adenomatous** is a type of mushroom-shaped growth or polyp, which may be precancerous. **Polyposis** is a condition where 100 or more polyps can form in the large intestines.

Fecal Occult Blood Test (FOBT) or FIT – Tests that check for hidden blood in the stool with a test kit you use at home. The doctor's office or a lab checks the kit for blood when it is returned.

Flexible Sigmoidoscopy – Flexible sigmoidoscopy is conducted at the doctor's office, clinic, or hospital. The doctor uses a narrow, flexible, lighted tube to look at the inside of the rectum and the lower portion of the colon.

Hereditary Non-Polyposis Colorectal Cancer (HNPCC) - Also known as, the Lynch syndrome is an inherited cause of cancer of the bowel.

Inflammatory Bowel Disease (IBD) - Inflammatory bowel disease is the name of a group of disorders that cause the intestines to become inflamed (red and swollen).

Polyp - An abnormal, often precancerous growth of tissue (colorectal polyps are growths of tissue inside the intestine).

Ulcerative colitis- A chronic gastrointestinal disorder that is limited to the large bowel (the colon). *Sources for definitions: National Cancer Institute and Centers for Disease Control and Prevention.*

2012 Federal Poverty Guidelines

Number of Persons in Family Unit	Poverty Line	Monthly	Hourly
1	\$27,925	\$2,327	\$13.44
2	\$37,825	\$3,152	\$18.20
3	\$47,725	\$3,977	\$22.96
4	\$57,625	\$4,802	\$27.73
5	\$67,525	\$5,627	\$32.49
6	\$77,425	\$6,452	\$37.25
7	\$87,325	\$ 7, 2 77	\$42.02
8	\$97,225	\$8,102	\$46.78
Each additional person, add	\$9,900		

The Wyoming Colorectal Cancer Screening Program uses 250% poverty guidelines to determine eligibility. Poverty guidelines are updated annually by the federal government. They are usually released by mid-February of that year. You can find the current poverty guidelines with calculated percentages at http://www.cms.hhs.gov/medicaid/eligibility/

Wyoming Colorectal Cancer Screening Program *Enrollment Application*

First Name	Initia	al	Last Na	me	Maiden N			n Nam	e (if applicab	ole)
Mailing Address	l	Cit	.y	State	Zip		Bir	th Date	· /	
Do you wish to be contacted by the program nurse for step-by-step guidance through the screening process? Yes No Don't Know If yes, what is the best time to reach you? Email address										
Home Phone	Work Phone		Cell P			How die		hear	about	the
Alternate Contact: Contact person: Relationship: Address: City: State: Zip: What race are you? American Indian Black/African American White Asian Pacific Islander Hispanic/Latino Unknown									sion ine Fair ite	
☐ Other ☐ Male				What	ic vour	 primary la	ancuna	?		
□ IVIAIC	- Fema	iic				Spanish [
Household income is determined by submission of previous year's Income Tax Return. Please attach this paperwork. How many people live on this income?			Highe	Highest grade in school you completed: circle one 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+						
Insurance Information (program; this question is for Wyoming residents that are u your healthcare provider of a insurance before they bill the W Do you currently have pri Yes No	data purposes only. ninsured and underin ny private insurance, /CCSP.) vate insurance?	The WC sured. P they mu	CSP serve lease notij est bill you	Do yo Do yo Do yo	art A onl ou have	Medicare? y? or Medicaid □ Yes	□ Par	t A& B	Yes	
☐ Yes ☐ No Family History How many family mem How many of How many family members	0 1 those family men	bers w. 1	2 3 ith colon 2	+ I cancer w 3+	Oon't Kno ere unde Don't	OW			nl cance	

Please re-print your name						
Personal History Have you ever had any of the follo please refer to the second page for common screen	wing tests? ening terms (please mark only one for each question)					
Fecal Occult Blood Test (FOBT) or FIT Test □ Yes Was your exam positive or negative? □ Positive □ Negative?						
Double Contrast Barium Enema (DCBE)						
= ·	□Don't Know Date/					
Sigmoidoscopy □ Yes □ No Were there polyps removed? □ Yes □ No	□Don't Know Date/					
If polyps were removed during your colonoscopy or sigmoidoscopy, how did your doctor describe the polyp? OtherOther						
Have you ever been told by a doctor, nurse, or other	health professional that you have had:					
Cancer of the colon or rectum Crohns Disease Familial Adenomatous Polyposis (FAP) Hereditary Non Polyposis Colorectal Cancer (HNPCC) Inflammatory Bowel Disease (IBD) Ulcerative Colitis	□Yes Date //					
Are you currently under a doctor's care for any of the above conditions? Yes Don't Know						
Primary Care Physician Information Please tell us who your primary doctor is: Name of clinic: Phone:	City:					
For office use only: Approved Date Needs Case Management	Denied Date					

Informed Consent and Release of Medical Please read and sign below:	Information
I want to be a part of the Wyoming Colorectal Can or program below). I understand that I must fall v program criteria in order to be eligible for enrollm in the program, I must sign below.	within the income guidelines and meet various
• If I am under 50 years of age, I know I can referral by my physician. The program's staff may	t pay for complications, adverse events, or or conditions such as Crohns Disease or other ry center or hospital about how I am going to
 My doctor, laboratory, clinic, radiology ur for and the results of my colorectal screening, dia program. 	nit, and/or hospital can give recommendations agnostic tests, and/or treatment services to the
± 	DH uses and disclosures of protected health
• My name, address, and/or other personal i This information may be shared with other organiz	approved by the program and/or The Centers outside researchers to learn more about colon
Signature	Date
Please Print Name	Date of Birth
Affidavit of Wyom Please read and sign:	ning Residency
I,	, swear or affirm under
I,(Please print your name) penalty of perjury of the laws of the State of Wyor at least 1 (one) year immediately prior to submission	ming that I have been a Wyoming resident for
I understand that this sworn statement is required benefit. I further acknowledge that making a representation in this sworn affidavit is punishable	false, fictitious or fraudulent statement or

Signature Date